“Distribution of resources amongst social groups in Anganwadi centers of Sangam Vihar, New Delhi, and Wayanad, Kerala.”

Dissertation Submitted to

THE IIHMR UNIVERSITY, JAIPUR
For the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

In

Rural Management

By

“Dushyant Singh Rathore ”

Under the Supervision and Guidance of

“Prof. Laxman Swaroop Sir”

2021

A Report on

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled "**Distribution of resources amongst social groups in Anganwadi centers of Sangam Vihar, New Delhi, and Wayanad, Kerala.**" is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Name of Student: Dushyant Singh

Date: 2-07-2021

ABSTRACT

Background:

Integrated Child Development Services (ICDS) is arguably one of the world's largest community-based programs, aimed holistically at improving child health, nutrition, and development. Towards this aim the scheme focuses on the health, nutrition, hygiene and related education of the mothers, pre-school education of the children aged between three to six, providing additional nutritional supplements for pregnant and nursing moms, development, monitoring and promotion of child health, and associations to primary healthcare services such as immunization and vitamin A supplements. There are more than 40,000 ICDS centers across India, playing a major role in the child development sphere. The program serves 82 million young children and more than 19 million pregnant and lactating mothers.

These services are provided at child-care centers or Anganwadi Centres. These centers function as the first-hand service providers to the women and children. With a workforce of 1.4 million women and a 2018-19 budget allocation of Rs 16,335 crore, the Anganwadi system forms the backbone of the country's ICDS program.

With a documented history in India that throws light on discrimination based on caste, religion, gender, economic status, and so on, it becomes particularly important to study the pattern of distribution of Anganwadi resources. Which group benefits the most and which the least? How do inter-caste, inter-religion disparities (or any other) affect the access and quality of services provided by Anganwadi Centers? To what extent, social faculties act as a barrier in accessing the services provided by Anganwadi Centers?

Aim and objectives:

To study the patterns of distribution of Anganwadi services and resources:

How many beneficiaries are availing Anganwadi services in identified Anganwadi centers in Delhi and Kerala? How much does the percentage of beneficiaries who regularly go to Anganwadi Centers (mentioned above) differ from each other concerning- Religion and b)

Category they belong to.

To identify whether lack of access is due to choice or discrimination?:

Whether the difference in access, as identified in the above question is due to the choice of the beneficiaries, or is it due to the discrimination they face due to belonging to a particular social group?

Methodology:

The present study was carried out at the urban Integrated Childhood Development Services Scheme (ICDS) block of New Delhi and the rural block of Wayanad from November 2019 to December 2019. It is a cross-sectional type of study.

Results:

I found that in both Delhi and Wayanad, the access to Anganwadi services is different among various social groups. While implied cases of discrimination along religious lines were observed in Delhi, no such instances were observed in Wayanad. The differentiated levels of access (where it is not due to discrimination), are mostly attributed to dissatisfaction over the quality of services or other administrative gaps in the delivery of the services.

In both cases where easy access to the Anganwadi services for the beneficiaries was disrupted, my paper suggests policy interventions to fix this gap.

Conclusion:

After careful analysis of the data, I conclude that Anganwadi centers in Delhi showed some implicit discrimanatory pracatises based on religion which played a role in impeding the access to Anganwadi centers. However, further research is required for concrete results. No discriminatory practises were observed in Wayanad, Kerala. The difference in access in both Delhi and Wayanad is majorly attributed to the obstancles leading from unsatisfactory delivery of services. I hope that the policy recommendations suggested in this paper will help in increasing the access to Anganwadi centers.

ACKNOWLEDGMENT

Firstly, I would like to thank my mentor **Prof. Laxman Swaroop Sir** ., for their constant support and guidance. I am grateful to you for always being ready with your feedback and thoughts, and encouraging me to undertake this project rigorously. I would also like to extend my deepest gratitude to IIHMR for giving us this opportunity. Lastly, I would like to thank Doctors For You (DFY) and the numerous local persons in Delhi and Wayanad for your companionship on the field and for helping us carry out door-to-door surveys.

INDEX

CHAPTER 1: INTRODUCTION

Integrated Child Development Services (ICDS) is arguably one of the world's largest community-based programs, aimed holistically at improving child health, nutrition, and development. Towards this aim the scheme focuses on the health, nutrition, hygiene and related education of the mothers, pre-school education of the children aged between three to six, providing additional nutritional supplements for pregnant and nursing moms, development, monitoring and promotion of child health, and associations to primary healthcare services such as immunization and vitamin A supplements. There are more than 40,000 ICDS centers across India, playing a major role in the child development sphere. The program serves 82 million young children and more than 19 million pregnant and lactating mothers.[1]

These services are provided at child-care centers or Anganwadi Centres. These centers function as the first-hand service providers to the women and children. With a workforce of 1.4 million women and a 2018-19 budget allocation of Rs 16,335 crore, the Anganwadi system forms the backbone of the country's ICDS program.[2]

With a documented history in India that throws light on discrimination based on caste, religion, gender, economic status, and so on, it becomes particularly important to study the pattern of distribution of Anganwadi resources. Which group benefits the most and which the least? How do inter-caste, inter-religion disparities (or any other) affect the access and quality of services provided by Anganwadi Centers? To what extent, social faculties act as a barrier in accessing the services provided by Anganwadi Centers?

My study attempts to understand how the various services in Anganwadi Centres are accessed by its beneficiaries across the social groups they belong to. The urban block of Delhi and the rural block of the Wayanad district in Kerala were my study fields. For my study, I selected three Anganwadi Centres each in the respective fields. I conducted a total of one hundred and twenty surveys of households in Delhi and Wayanad, along with interviews of the Anganwadi Worker and the Anganwadi Helper in the Centres I selected.

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[1]-Annabelle Timsit, „Inside India"s ambitious effort to provide early care and education to 400 million kids, Quartz India, accessed from https://qz.com/india/1584703/indias-icds-anganwadi-system-is-a-challenged-but-impressive- effort/

[2] - Accessed from https://thewire.in/women/in-odisha-a-workforce-of-women-with-a-near-impossible-mandate

I found that in both Delhi and Wayanad, the access to Anganwadi services is different among various social groups. While implied cases of discrimination along religious lines were observed in Delhi, no such instances were observed in Wayanad. The differentiated levels of access (where it is not due to discrimination), are mostly attributed to dissatisfaction over the quality of services or other administrative gaps in the delivery of the services.

In both cases where easy access to the Anganwadi services for the beneficiaries was disrupted, my paper suggests policy interventions to fix this gap.

CHAPTER 2: LITERATURE REVIEW

Much of the literature available on Anganwadi Centers, in the form of policy reports and independent studies, focus on Anganwadi Centers as an institution and institutional problems associated with it visa vi flow of funds, the hierarchy of administration, overburdening of Anganwadi workers and so on and the ways to address these specific concerns. Less attention has been given to the discriminatory practices associated with the Anganwadi Centers. Literature available on it is scattered and a few.

Writing in Economic and Political Weekly Nidhi Sadana Sabharwal (Caste, Religion and Malnutrition Linkages, Economic and Political Weekly, Vol. 46, No. 50 (DECEMBER 10, 2011), pp. 16-18) shows how the problem of malnutrition is contingent upon one's caste or religion. For example, she shows how, while nationally the chronic energy deficiency rate is about 40.5% for all women, women from the sc and st groups have an 8% and 13% higher incidence respectively of undernutrition than those from the "others". Similarly, amongst children the likelihood of sc and st children being malnourished is about 1.4 times that of children from the "other" category. The data is computed from the National Family Health Survey- 3(2005-2006). Although it doesn't deal specifically with Anganwadi and the role that the Anganwadi play in the perpetuation of this discrimination at the grass-root level leading to the disparity between children and women from similar economic backgrounds, this calls for a closer study into the functioning of Anganwadi, for they being the lodestar of governmental policy paraphernalia geared towards eradicating malnutrition.

A more detailed study was done by Snghamitra S. Acharya in (Sangamitra, Acharya (2010): "Public Health Care Services and Caste Discrimination: A Case of Dalit Children" in Thorat Sukhadeo and Newman Katherine (ed.), Blocked by Caste-Economic Discrimination and Social Exclusion in Modern India (New Delhi: OUP) where they mapped discrimination under various indexes viz on the count of AWWS not touching Dalit children, making them sit separately, serving them food at the last, etc. The results were astounding. In 87% of the cases, children experienced untouchability, in 86% of the cases they were made to sit separately, and in 98% of the cases, they were served food last.

Jan Sahas conducted a similar study in the Dewas district of Madhya Pradesh and came to a similar conclusion(Jan Sahas Social Development Society (2009): "Exclusion and Inclusion of Dalit Community in Education and Health: A Report", Dewas, Madhya Pradesh). They concluded that in 92% of the villages surveyed the ANM does not visit the Dalit localities and 42% of the women are deprived of health services. Women disclosed that since the Anganwadi Centers are located in the houses of upper caste people they are not allowed to enter the centers and are made to wait outside and there they have to wait for long hours and are treated at last. Since the AWWS and ANMS don't visit the Dalit bastis they never get to know about pregnant women and hence these women do not make it to the official list and are systematically excluded from health and maternity benefits which they are entitled to.

CHAPTER 3: RESEARCH QUESTIONS

To study the patterns of distribution of Anganwadi services and resources:

1. How many beneficiaries are availing Anganwadi services in identified Anganwadi centers in Delhi and Kerala? How much does the percentage of beneficiaries who regularly go to Anganwadi Centers (mentioned above) differ from each other concerning- a) Religion and b) Category they belong to.

To identify whether lack of access is due to choice or discrimination?:

2. Whether the difference in access, as identified in the above question is due to the choice of the beneficiaries, or is it due to the discrimination they face due to belonging to a particular social group?

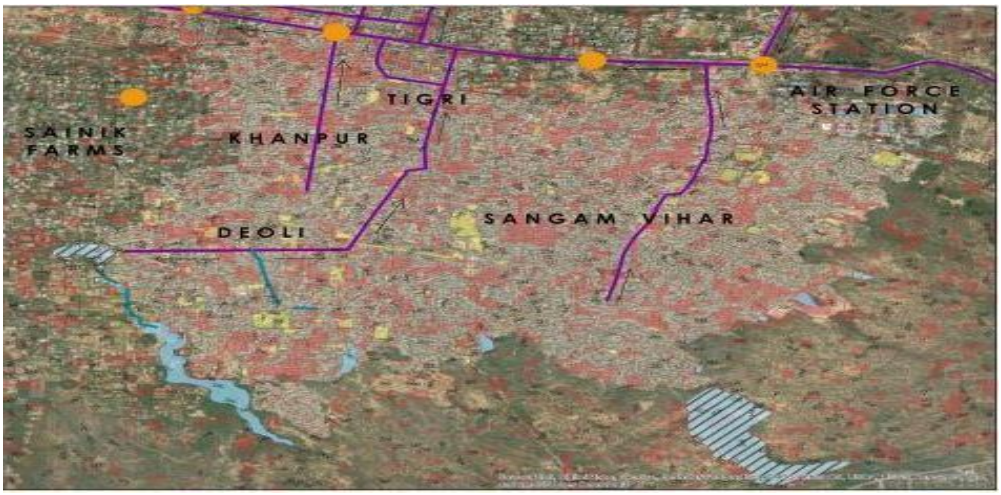
CHAPTER 4: METHODOLOGY

Study area and design

The present study was carried out at the urban Integrated Childhood Development Services Scheme (ICDS) block of New Delhi and the rural block of Wayanad from November 2019 to December 2019. It is a cross-sectional type of study.

Delhi

As of 2015, the ICDS projects of New Delhi consists of 95 sanctioned projects in which a total of 10,897 out of 11,150 sanctioned AWCs are operational. There are 10.8 lakh beneficiaries including infants from 0–3 years [5.2 lakh]; children between 3–6 years [3.8 lakh]; pregnant, nursing, and lactating mothers [1.7 lakh]. For the operational aspect of the project, extensive literature and local people were consulted to select the study area in New Delhi. One such research classifies AWCs functioning in New Delhi in 4 distinct categories, that is, AWC operational in slum and unauthorized area, semi-rural and rural area, school-based AWC, and model HUB center. Due to the limitation of time, the study is only restricted to examining the AWCs in the slum and unauthorized area of Sangam Vihar-II. Sangam Vihar is a high-density unauthorized colony situated in South Delhi with a population of roughly 1 million in five square kilometers. The reason behind selecting Sangam Vihar is that it is inhabited by migrants from all over India, providing the advantage of the diverse pool of sample size, a prerequisite for studying different social groups accessing benefits under Anganwadi.



Wayanad

Wayanad for administrative purposes is divided into 4 blocks; Kalpetta, Sultan Bathery , Manthavady, and Panamaram. There are in all 874 functioning Anganwadi centers in the Wayanad district catering to a population of 817,420(acc. to 2011 census). Due to its centrality and it's demographic diversity, after my preliminary field visits and talks with my local guides Doctors For you (DFY) chose the Kalpetta block for my study. Kalpetta is also the district headquarters of the Wayanad district and has a population of roughly about 193646 with 10% and 7% of the population comprising people belonging to Scheduled Tribes and Scheduled Castes. Roughly about 47.7% of the population categorize themselves as Hindus while Muslims and Christians comprise 38.95% and 12.14% respectively. The block comprises 9 Gram Panchayats and for my study, I chose 2 Anganwadi Centres from Muttil Grama Panchayat and 1 from Meppadi.

Grama Panchayat Boundary Map of Wayanad

Source: JICA Survey Team (2014)

Study period

The study was conducted in 21 days from 01 March 2021 to 21 March 2021. Daily visits (except Sundays) were made to AWCs and households between 9:30 AM to 1 PM. The above time was chosen due to two reasons, firstly AWCs remained operational during this time which ensured the presence of a maximum number of beneficiaries at the time of visit, and secondly, households were usually free to talk in the given period.

Definitions

For the table given below and for this study, the meaning ascribed to certain terminologies is as follows;-

a. Social group; A group of people sharing identity and interrelationship, such as based on religion, economic status, etc.
b. Beneficiary- An individual who is eligible for availing benefits under the ICDS scheme. An individual must fall in of the following categories;-
    i. Infants between 0-3 years old.
    ii. Children between 3-6 years old
    iii. Lactating and pregnant women – 15-46 years old
c. Total number of households- Aggregate of households surveyed in Sangam Vihar, New Delhi, and Wayanad, Kerala.
d. Eligible household- A household which is eligible to avail any of the Anganwadi services mentioned below:

Services	Target Group	Interventions	Service provided by
Supplementary Nutrition	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	i. Morning Snack, Hot Cooked Meal and take home ration as per norms ii. Bridge between the Recommended Dietary Allowance (RDA) and the Average Daily Intake (ADI) of beneficiaries iii. Compliance with the Supplementary Nutrition Rules is issued by MWCD in 2017.	Anganwadi Worker (AWW) and Anganwadi Helper (AWH) Ministry of women child and development

Pre-School Education	Children 3-6 years	i. Non-formal pre-school education based on semi-structured play & learning method. i. Monthly monitoring & promotion of child growth & Developmental milestones ii. Guidance to Parents through Home visits iii. Make children school ready with holistic development activities iv. Engage with Parents group / Mothers group to enable them to train their children through play mode.	AWW and AWH Ministry of women child and development.
Nutrition & Health Education	Women (15-45 years)	i. Skilled one to one counseling through home visits on Infant & Young Child feeding Promotion. ii. Maternal care counseling iii. Nutrition counseling to all the women in the age group of 15 – 45 years. iv. Care, Nutrition, Health & Hygiene Education. v. Community-based care and management of underweight children.	AWW/ Auxilliary Nurse Midwife (ANM) /ASHA (Accredited Social Health Activist)/Medical Officer (MO) Ministry of women child and development and Ministry of Health and Family Welfare.
Immunization	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	i. Immunization and Micronutrient Supplementation	ANM/MO/ASHA/AWW as facilitators Ministry of Health and Family Welfare.
Health Check-up	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	i. Antenatal Care (ANC)/ Post Natal Care (PNC)/Janani Suraksha Yojna (JSY) ii. Support for Integrated Management of Neonatal & Childhood Illness (IMNCI)/ Janani Shishu Suraksha Karyakram (JSSK) iii. Identification of severely	ANM/MO/ASHA/AWW as facilitators Ministry of Health and Family Welfare.

		underweight children requiring medical attention& support community	
Referral Services	Children below 6 years, Pregnant & Lactating Mothers (P&LM)	i. Referral of severely underweight to the health facility. ii. Referral for complications during pregnancy. iii. Referral of sick new-borns and sick children.	ANM/MO/ASHA/AWW as facilitators Ministry of Health and Family Welfare.

Sample Size

I. **Delhi:** There are approximately 40 Anganwadi centers in Sangam Vihar. For purposes of collecting data, the study focused on areas of Sangam vihar inhabited by people of various social groups. With the local help, the surveyors identified the Gurjar Chowk area of Sangam Vihar comprising different social groups. Due to the paucity of time, based on random sampling, the surveyors identified three Anganwadi Centers, Anganwadi no. 95, 85, and 75 situated in different Galis and catering to the population of 1000 (approx) individuals respectively.

II. **Wayanad:** Wayanad has a total of 874 Anganwadi Centres of which roughly about 200 are in Kalpetta. Through the help of a local NGO Doctors For You(DFY) and my preliminary field visits, I narrowed down on 3 particular Anganwadi Centers namely Ambuthi and Palamangalam from Muttil Grama Panchayat and Mundupara from Mepaddi Gram Panchayat for my study. The concerned Anganwadi Centers were chosen because of demographic diversity, all three Anganwadi Centers cater to a significant number of tribal populations. Of the 3, the Anganwadi in Ambuthy caters specifically to the tribal population.

Sampling: For sampling, primarily the study relies on conducting household surveys of the eligible households under the ICDS scheme. The households were interviewed with the help of a rapid assessment questionnaire, semi-structured interview questions, and in some cases, focus group discussions. For the supplementary assessment of Anganwadi Centers, surveyors also conducted interviews of Anganwadi workers and helpers via conversation mode. All three Anganwadi Centers comprised 1 AWW and 1 AWH each. The total sampling of the study was

58 (52 households and 6 Anganwadi workers) for New Delhi and 66 (60 households and 6 Anganwadi workers) for Wayanad.

Table 1 and 2 mentioned below presents the breakup of the sample collected based on social groups in New Delhi:

Category of households	**Eligible households**	**Households regularly accessing Anganwadi services**
Hindus	31	14
Muslim	21	17

(Table 1)

Nature of households	**Eligible households**	**Households regularly accessing Anganwadi services**
General	11	9
OBC	12	4
SC	3	2

(Table 2)

Tables 3 and 4 present the breakdown of beneficiaries surveyed in Wayanad comprising a cross-section of social groups.

S.No.	**Social Group by Religion**	**No. of eligible households**	**No. of households availing services**
1	Hindus	33	20
2	Muslims	19	9
3	Christians	7	3

(Table 3)

S. No.	Social group by category	No. of eligible households	No. of households availing services
1	General	9	3
2	OBC	22	10
3	SC	6	3
4	ST	22	15

(Table 4)

Data collection

During visits, a pre-designed standard questionnaire (appendix 1) was used to assess the distribution of Anganwadi resources amongst different social groups. The questionnaire was pre-designed to ensure the homogeneity of the nature of data collected.

Data analysis

The data were entered, tabulated, and analyzed using Microsoft Excel 2010. The data were regularly checked for any errors.

CHAPTER 5: DATA ANALYSIS

Wayanad Analysis

I. Religion and Access to Anganwadi Centers

Only about 54% of the respondents I surveyed in Wayanad are accessing one or more services from the Anganwadi Centers. 60% of eligible Hindu families are regularly availing, 47% of Muslim families are regularly availing and 42% of Christian families are regularly availing at least one Anganwadi services*.

Category of households	**Eligible households**	**Households regularly accessing Anganwadi services**
Hindus	33	20 (60%)
Muslims	19	9 (47%)
Christians	7	3 (42%)

***** I am not taking into consideration one respondent who said that they do not (officially as well) follow any religion.

A. Pre-school education

The percentage of total households that avail Pre-School education from the Anganwadi Centers is only 41%. That is, only 7 families out of 17 families having children within the 3-6 ages are sending their children to the Anganwadi for pre-school education. While 80% of Christian households are sending their children to the Anganwadi Centers only about 33% and 16% of Hindus and Muslims are sending their children to the Anganwadi Centers.

Category of households	Eligible households	Households accessing Pre-School education
Hindu	6	2 (33%)
Muslim	6	1 (16%)
Christians	5	4 (80%)

B. Supplementary nutrition

Supplementary nutrition consists of the ration given to adolescent girls, pregnant women, and lactating mothers. These include Black Gram (1-1.5 Kgs), Coconut Oil (1-1.5 Liters), and Wheat (1-1.5 Kgs) given to the pregnant women (from their second trimester) and adolescent girls (only from the ST families). Lactating mothers are provided the same for the first six months after which a special *Amrutam Podi* is provided which is given to the newborn till three years of age.

Out of the eligible 52 households, about 60% of them are availing the various supplementary nutrition from their Anganwadi Centers. While 82% of all eligible Muslim households are availing, only 51% and 25% of Hindu and Christian households are availing these from their Anganwadi Centers.

Category of households	Eligible households	Households accessing supplementary nutrition.
Hindu	31	16 (51%)
Muslim	17	14 (82%)
Christians	4	1 (25%)

C. Nutrition and Health

The table shows the access patterns of the different religious groups to Health and Nutritional Services under the Anganwadi Centers.

Vitamin A and Iron-Folic Acid Supplements: Only two households in the three Anganwadi Centres I surveyed responded to be getting Vitamin A supplements and only a total of 6 households responded to be receiving Iron - Folic Acid supplements.

Immunization: Only 6 families have received vaccines via the interventions of the Anganwadi Centers.

Health Check-ups: A doctor visits Anganwadi once in every month. During this visit, the weights of the children are recorded and the health of pregnant women and lactating mothers are assessed. While 32% of the Hindu households visit the doctors, only 11% of Muslim households visit and 4 out of 6 households, ie, 66% of Christian households visit.

Treatment of Minor Ailments: None of the families avail this service from the doctors' visits in the Anganwadi Centers.

	Vitamin A	Iron and Folic Acid	Immunization	Health Check up	Treatment of Minor Ailments
Eligible Hindu Households	31	31	31	31	31
Hindu households accessing services	1	4	2	10	0
Eligible Muslim Households	18	18	18	18	18
Muslim household accessing services	1	2	4	2	0
Eligible Christian Households	6	6	6	6	6
ChristianHouseholaccessing services	0	0	0	4	0

II. Category-wise Access to Anganwadi Centers

a. Pre-school education

Out of the total 18 households eligible for availing pre-school education only 8 households avail the services which are 44%. While 4 out of the 5, i.e, 80% eligible households belonging to the General Category avail pre-school education from the Anagnwadis, only one family among the SC, ST and OBC categories send their children to the Anganwadi Centers. The corresponding percentage for households belonging to these categories are OBCs 16%, SCs 50%, and STs 20%.

Nature of households	**Eligible households**	**Households regularly accessing pre-school education**
General	5	4 (80%)
OBC	6	1 (16%)
SC	2	1 (50%)
ST	5	1 (20%)

b. Supplementary Nutrition

For supplementary nutrition, out of the 44 households eligible for supplementary nutrition, 30 households are receiving supplementary nutrition from the Anganwadi Centers, which is 68 %. While all four SC families (100%) and 15 out of 17 (88%) of OBC families, which are eligible are receiving supplementary nutrition. About 62% of the ST families are receiving Supplementary nutrition. One family(14%) in the general category is receiving supplementary nutrition.

Nature of households	**Eligible households**	**Households regularly accessing Anganwadi services**
General	7	1 (14%)
OBC	17	15 (88%)
SC	4	4 (100%)
ST	16	10 (62%)

c. Health and Nutrition

Out of the total 7 eligible general category households 57.14 % avail health check-up facilities. Amongst OBCs just about 5.88 % access Vitamin A supplements whereas 17.64 % get Iron and folic acid, 23.52% are immunized, 17.64% go for health checkups.

Amongst SCs only 1 out of 4 i.e. 25 % go for health checkups. Likewise, amongst STs 6.25% receive Vitamin A supplements, 18.75% receive iron and folic acid, 12.5 % are immunized, 56.25% go for regular health checkups and no one goes to get their minor ailments treated.

	Vitamin A	Iron and Folic Acid	Immunization	Health Check up	Treatment of Minor Ailments

Eligible General households	7	7	7	7	7
General household accessing services	0	0	0	4	0
Eligible OBC households	17	17	17	17	17
OBC households accessing services	1	3	4	3	0
Eligible SC household	4	4	4	4	4
SC households accessing services	0	0	0	1	0
Eligible ST households	16	16	16	16	16
ST households accessing services	1	3	2	9	0

Delhi

I. Religion and access to Anganwadi Centers

Overall, 59.61% of beneficiaries are availing one or more Anganwadi services. 26.92% Hindus visit Anganwadi regularly as against 32.6% Muslims.[3] Low levels of Hindu population availing Anganwadi services can be attributed to the availability of alternatives such as private schooling and hospital care, low quality of Anganwadi services, and lack of awareness. On the contrary, Muslim households do not access some Anganwadi services due to issues in access, low quality of Anganwadi services, availability of alternatives, and lack of proper knowledge regarding the schemes of Anganwadi.

Category of households	Eligible households	Households regularly accessing Anganwadi services
Hindus	31	14
Muslim	21	17

a. Preschool education

The children between 3-6 years are beneficiaries of Anganwadi preschool education. The table presented below presents the bifurcation of Hindu and Muslim households sending their children between the age of 3-6 years to Anganwadi. Only 30.23% of eligible households access Anganwadi Centers for preschooling as against 6.9% Hindu households access Anganwadi Centers for preschooling.

[3] -7.8% of the total beneficiaries did not reveal their religion.

Category of households	Eligible households	Households accessing preschool education
Hindu	24	10
Muslim	19	03

b. Supplementary nutrition

Supplementary nutrition consists of cooked food and/or take-home ration for children between the age of 0-6 years and pregnant and lactating mothers. The purpose is to fulfill the bridge between the Recommended Dietary Allowance (RDA) and the Average Daily Intake (ADI) of beneficiaries. The three Anganwadi Centers I surveyed, majorly provided cooked lunch to children coming to Anganwadi in the age group of 3-6 years. There were few instances where children below 3 years also received the cooked meal. Concerning pregnant women and lactating mothers, the Delhi government provides a one-time cash benefit of 5000 rupees distributed in trenches of 3000 and 2000. Apart from the cash, the pregnant and lactating mothers did not get cooked meals or take-home ration.

The analysis of the table shows that 52.1% of the eligible households access Anganwadi for supplementary nutrition. 30.4% of Hindu households access supplementary nutrition from Anganwadi as compared to 21.7% of Muslim households.

Category of households	Eligible households	Households accessing supplementary nutrition
Hindu	27	14
Muslim	19	10

c. Health & Nutrition

The table below shows the access of different religious groups to Anganwadi services. 70% Muslim households accessed vitamin A supplements as against 77% Hindus in the past 3 months; also 55% Muslims accessed iron and folic acid supplements in the past 3 months as against 62% Hindu households. However, this gap decreases concerning immunization and health checkup. 20% of Muslim households got immunization for the last child as compared to 18% Hindus. Similarly, for health checkups, 50% of Muslim households stated that they got a health checkup from Anganwadi in the past one month as against 48% Hindu households. Concerning treatment for minor ailments, 75% of Muslim households agreed to visit Anganwadi Centers as against only 48% Hindu households.

	Vitamin A	Iron and Folic Acid	Immunization	Health Check up	Treatment of Minor Ailments
Eligible Hindu Households	27	27	27		27
Hindu households accessing Anganwadi services	19	17	5	13	13
Eligible Muslim Households	20	20	20	20	20
Muslim households accessing Anganwadi	14	11	4	10	15

II. Caste and access to Anganwadi Centers

In my study, surveying caste became more challenging than surveying religion. A significant number of respondents did not either reveal their caste or merged themselves with the general population. I arrived at that conclusion from the observations in the field. 18% of respondents did not reveal their caste. Overall, 57% of households (on caste) are regularly accessing Anganwadi services, 34.46% were general, 15.38% were OBCs, and 7.6% were SCs households. The survey could not find any concrete reasons for low levels of access amongst SCs as compared to OBCs and general category households. Concerning caste, one of the biggest limitations of the study is the non-desirability of people to disclose their actual caste.

Nature of households	Eligible households	Households regularly accessing Anganwadi services
General	11	9
OBC	12	4

SC	3	2

a. Preschool education

Overall, 72.2% of eligible households access Anganwadi for preschool education. 27.7% of children belonging to the General category, 33.3% OBCs, and 11.1% SC households access Anganwadi Centers for preschool education.

Nature of households	**Eligible households**	**Households regularly accessing preschool education**
General	6	5
OBC	9	6
SC	3	2

b. Supplementary nutrition

A total of 45.8% of eligible households are accessing Anganwadi for supplementary nutrition. 12.5% general category households, 25% OBC households, and 8.3% SC households agreed to obtain supplementary nutrition.

Nature of households	**Eligible households**	**Households regularly accessing Anganwadi services**
General	11	3
OBC	10	6
SC	3	2

c. Health and Nutrition

In the OBC category, 0% are accessing vitamin A supplements, 8.3% are accessing iron and folic supplements, 50% are accessing immunization, 8.3% are accessing health check-up services, 0% are accessing Anganwadi center for treatment of minor ailments.

In SC category 33% are accessing vitamin A supplements, 33% are accessing iron and folic supplements, 66 % are accessing immunization, 66% are accessing health check-up services, 33% are accessing Anganwadi center for treatment of minor ailments.

CHAPTER 6: DISCUSSION

I. Religion and Access to Anganwadi Centers in Wayanad

Pre school education

Among the Hindu households which do not avail of the pre-school services of the Anganwadi Centres, one household reported that they send their children to private Kindergarten schools instead of the Anganwadi Centers. Among the Muslim households, one household reported that the Anganwadi Centre is too far from their home and nobody is free in their house to take the kid to the center. Another household also reported that they send their child to the private kindergarten instead of the Anganwadi. Nevertheless, about 7 families were unhappy with the unfriendly behavior of the Anganwadi teacher and one has raised complaints about prolonged absence. Two households mentioned that they prefer to directly admit their kids into the primary section and not go through pre-school. One Muslim family also mentioned that they do not know how to enroll their children. The Christian family which did not send their kid to the Anganwadi responded that they prefer private kindergartens. I can see a notable preference for private pre- school education over that provided in Anganwadi Centers.

Many households mentioned that they wish to have better teaching facilities in the Anganwadi Centers and 5 households mentioned that the Anganwadi must provide additional incentives like free bags and uniforms for the children. Moreover, the need for better infrastructure in the Anganwadi Centers (fans, more space, regular electricity, mosquito repellents) was mentioned by 4 families.

The main reason why households prefer private schools over Anganwadi Centers is because of the better learning experience at private schools. And then because of a lack of professionalism at Anganwadi Centers.

Supplementary nutrition

A notable percentage of Hindu families are not availing the Supplementary nutrition from the Anganwadi Centers. While one family mentioned that they did not have the time to enroll for the service with the Anganwadi, another family mentioned that they do not have any idea about such services of the Anganwadi. One of the Hindu families also complained that the quantity of the

supplements received is too low. One of the Christian families also mentioned that they had no information about the services of the Anganwadi.

Notably, a total of seven families surveyed (including 3 Hindu families) recommended that additional nutritional supplements are to be given to the adolescent girls than what is currently given. Other recommendations include a supply of diapers for the babies, menstrual support, and vocational training for adolescent girls. Additionally, two families also recommended the distributions of rice, eggs, and milk.

From the observation, two plausible reasons emerge as to why households are not able to avail Anganwadi services, one because of lack of outreach on the part of Anganwadi Centers and two because of what all is being provided at Anganwadi Centers in the form of supplementary nutrition is not adequate.

Health and Nutrition

All families across religions have reported having received the stipulated dosage of vaccines for their children. But this was primarily done through the PHCs in the area and not the Anganwadi Centers.

III. Category-wise Access to Anganwadi Centers

Five families from the OBC category have raised complaints about the unfriendly behavior of the Anganwadi Teacher or Helper and one family even recommended that the teacher be replaced. The one SC household which did not send their children to the Anganwadi mentions that they are sending their children to a private kindergarten. There were complaints about the bad infrastructure of the Anganwadi from one of the ST families, two of them recommended for a better quality of teaching in the Anganwadi and one of them recommended better nutritious lunch for the kids that includes eggs and rich vegetables. The one General category family prefers to send their child to a private kindergarten.

Three of the general category families that send their children raised complaints about poor teaching and strongly recommended better infrastructure for the Anganwadi Centers. One of the recommendations from an ST household mentioned incentives like free bags, uniforms, etc. to be

provided for the children.

The reasons why households do not send their wards to Anganwadi Centers are threefold, One because of availability of private-sector education, two for want of poor infrastructure, and three because of the behavior of Anganwadi staff. Though the households did not mention any communal bias it emerges from the data that as many as 5 OBC households complained of the unruly behavior of Anganwadi staff.

Supplementary nutrition

Of houses not receiving supplementary nutrition in the general category, one family responded that they do not have information about these services in the Anganwadi, three of them raised recommendations that supplementary nutrition for adolescent girls be extended to their category. In the ST categories, two families expressed dissatisfaction with the quantity of the wheat and oil that the Anganwadi distributes. Families in the OBC categories recommended better nutritional options for pregnant women and one family recommends the extension of supplementary nutrition to their category.

It emerges from the observation that a significant no. of people feel that what is being provided in the form of supplementary nutrition is insufficient and this is the reason why some of the households let go of the benefits altogether. The reasons why people are not availing of the services are two-fold, firstly because of ignorance and second because of the presence of other healthcare service providers, private as well as state- run. No overt or covert reference was made towards any communal bias on the part of Anganwadi staff.

II. Religion and Access to Anganwadi Centers in Wayanad

Pre School education

In the discussion on low access, some Muslim households revealed that the Anganwadi worker exhibited impolite behavior towards them. Many also revealed that the Anganwadi helper (who usually goes door to door to call the children to attend the Anganwadi) does not call upon them for sending their children to Anganwadi. Some also claimed that Anganwadi workers explicitly showed discrimination towards their religion. In discussion with one of the Anganwadi workers, she expressly agreed to not visiting Muslim households for Anganwadi purposes due to eating habits of Muslims which she deemed unholy. She also said that Muslims do not access Anganwadi services due to their orthodox religious beliefs which makes her task extremely difficult.

Supplementary nutrition

Muslim households are less likely to receive supplementary nutrition from Anganwadi Centers than Hindu households. One of the biggest reasons that emerged is a less diverse palette. According to the discussions with Muslim households, Anganwadi Centers only serve vegetarian food which is not preferred by them. Another reason that emerged from one of the Anganwadi Centers is the lack of motivation amongst the Anganwadi workers to call children to attend Anganwadi Centers.

In terms of pregnant and lactating mothers, since the sample was a migrant population, many of the pregnant women traveled to their hometowns in UP and Bihar during pregnancy and early childhood care. One of the biggest trends that emerged from the discussion is likeness towards take-home ration and cooked meals as against the cash benefits (as given by the Delhi Government). Almost none of the pregnant women received full payment of the cash benefit. Any of the pregnant women mentioned no explicit incidence of discrimination.

Health and nutrition

As against the trend in supplementary nutrition and micronutrient, more Muslims prefer

Anganwadi Centers for primary health care services such as health checkups, treatment for a minor ailment, etc. Concerning health care services, higher proportions of Hindus prefer private services as against the services offered by Anganwadi Centers due to lack of trust in the efficiency.

The difference between the access to vitamin A, Iron, and folic acid tablet, etc., is attributed to lack of awareness. Both Hindus and Muslim households mentioned that the Anganwadi worker and helper do not adequately inform them regarding the availability of the above services to beneficiaries. However, as discussed below in aforegoing sections, Anganwadi helper is less likely to visit a Muslim household than Hindu households. Thus, even in this case, the social determinant of health is an important consideration.

Caste and access to Anganwadi Centers

Pre school education

Though the over data on access to preschool education seems promising in the case of caste, as mentioned above, the limitation of the study relating to the non-disclosure is to be kept in mind. However, similar to religion, the eligible households who are not sending their children to Anganwadi Centers, send them to low-cost private schools in the vicinity. These households, along with the ones sending their children to Anganwadi showed displeasure over the quality of the infrastructure but did not bring forth any specific discriminatory practice. Probably, the hesitation and tendency to hide their caste stopped them from highlighting such practices.

Supplementary nutrition

Of houses not receiving supplementary nutrition in the general category, the majority of the households complained regarding the infrastructure of the Anganwadi centers. They showed a lack of trust in the quality of supplements provided by the center. In the OBC households, as I can see out of all the categories, they access supplements in the largest number. Here, also families expressed their disappointment with the delivery and the quality of services provided by

the center. Families in the SC access less supplementary nutrition as compared to other households, however, they did not mention any explicit or implicit discriminatory behavior.

Health and Nutrition

In general category 0% are accessing vitamin A supplements, 18% are accessing iron and folic supplements, 63% are accessing immunization, 36% are accessing health check-up services, and 9% are accessing Anganwadi center for treatment of minor ailments.

The general trend in all the categories as if visible is that people do not have proper access to vitamin A supplements, iron, and folic supplements. Wherease services such as immunization are highly accessed by the beneficiaries in all three categories. The reasons why people are not availing of the services are two-fold, firstly because of ignorance and second because of the presence of other healthcare service providers, private as well as state-run. No overt or covert reference was made towards any communal bias on the part of Anganwadi staff.

CHAPTER 7: RECOMMENDATIONS

I. WAYANAD

From my data analysis, in light of the lower number of eligible families sending their children to Anganwadi Centers and dissatisfaction with the nutritional support for women and girls from the Anganwadi Centers, I focus on two pressing areas which need attention and policy interventions in Wayanad Anganwadi Centers: a) Enabling more families to send their children to the Anganwadi Centers and b)Enabling better support for Adolescent Girls, Pregnant women and Lactating Mothers from the Anganwadi Centers

Given the heavy workload assigned to the Anganwadi workers/Anganwadi helpers (from the government side), I found a decrease in the learning time and general teacher-student interaction. I strongly recommend measures to reduce the administerial workload on the Anganwadi Teacher and improve the quality of learning in the Anganwadi Centers.

I recommend hiring additional help in the Anganwadi Centers as a part-time employee assigned only with the responsibility of carrying out the administrative work under the supervision of the Anganwadi Teacher. This way, the teacher could increase their focus on the quality of the learning time with the children while on the side, supervising the part-time recruit.

To make incentives for the children and family to avail of the Pre-school services I recommend providing better teaching aids for the teachers and toys to play with for children in the Anganwadi centers. Better infrastructure in terms of more space for play and fans, lights, etc. are indispensable. Moreover, it should be the responsibility of Anganwadi to make the beneficiaries aware of the benefits they are being provided with and their access. So, the community outreach by the Anganwadi towards beneficiaries is also necessary which enables beneficiaries to know about and access their benefits.

To enable better support for adolescent girls, pregnant women, and lactating mothers from the Anganwadi Centers: Firstly, I suggest improving the nutritional content in the take-home

ration given from the Anganwadi Centers for pregnant women and lactating mothers. Providing staple diets like rice, eggs, and milk are recommended in the ration.

Secondly, currently, there is the policy through which Anganwadi provides nutritional supplements to adolescent girls but specifically who belongs to the category of Scheduled Tribes. In considering that many other beneficiary families in other categories are unable to have nutritious food owing to various reasons, this policy should be extended as per the need-basis so that the beneficiaries to give nutritional supplements for adolescent girls.

Thirdly, taking into consideration, the consistent recommendation raised by the Anganwadi beneficiaries in the area I surveyed I recommend starting vocational courses at a district- level with a cluster of Anganwadi Centers for women and adolescent girls. Moreover, the awareness programs should be conducted for adolescent girls, pregnant women, and lactating mothers according to their menstrual health, health, and their children's health respectively.

II. DELHI

Based on my literature review and field observations, some recommendations I feel might improve the access of beneficiaries to Anganwadi centers in Delhi, leading to improved social benefits to individuals and households.

The first and most important recommendation is to diversify the food palate for children. As per the official data for the Integrated Child Development Scheme present on the website of the Department of Women and Child, Government of Delhi, the recommended food to be served to the for children aged 0-6 years, pregnant/lactating women are: Vegetable Pulao, Vegetable Khichri, Namkeen Dalia, Sweet Dalia, Sweet Rice. On observation of the food palate, I notice that it lacks high protein foods and also be modified to consider the diverse food choices of various communities by including non-vegetarian options.

To diversify the food palate, I believe that the allocated cost to be spent on a meal is Rs 2 per beneficiary[4] is too less to maintain a diverse food menu. This allocation also affects the quality

[4] -Source: http://www.wcddel.in/icds.html

of food being served to the beneficiary and leads to a rise of dissatisfaction amongst some beneficiaries. An increase in the allocation per beneficiary might lead to improved access to beneficiaries.

I also recommend that the remuneration provided to an Anganwadi Worker (AWW) and Anganwadi Helper (AWH)be increased. Currently, it is a total paid by the Government of India and Government of the State, that was revised by the Government of India as well as Government of Delhi, which is as follows[5]:

Government of India

i. AWW (Main Anganwadi Centers) -----From Rs 3000 to Rs 4500 + Performance Incentive of Rs 500 per month
ii. AWW (Mini Anganwadi Centers)------ From Rs 2250 to Rs 3500 + Performance Incentive of Rs 500 per month.
iii. AWH ---- From Rs 1500 to Rs 2250 + Performance Incentive of Rs 250 per month

Government of Delhi

i. AWW----- From Rs 2300 to Rs 6678
ii. AWH From Rs 1150 to Rs 3339

The AWW and AWH are also involved in administrative works as well as activities related to other schemes. This has led to the overburdening of work on these officials, probably leading to a reduction in the non-office hours they enjoy. I believe the least that can be done is to monetarily compensate them for the extra work hours. In the specific case for Delhi, even though the remuneration has been revised by both the Government of India and Government of Delhi, the maximum earnings an AWW and AWH can take home is Rs 11678 and Rs 5839 respectively. This might be above the national minimum wage of unskilled labor (if one assumes for understanding purpose, but is not the case) but is less than the minimum wage stipulated for an unskilled worker by the Government of Delhi which is Rs 14842. Keeping this anomaly in mind I would recommend revising the remuneration to that of the stipulated minimum wage by the Government of Delhi. Also, if a performance-based incentive is added in the remuneration

[5]Source: https://pib.gov.in/PressReleasePage.aspx?PRID=1578557 and http://web.delhi.gov.in/wps/wcm/connect/doit_wcd/wcd/Home/Integrated+Child+Development+Services/Honorarium

component of Delhi, I believe it might lead to more outreach and improved access to beneficiaries as the AWWs and AWHS might be more motivated towards their work and its improvement.

Further, the recruitment guidelines notified by the Government of Delhi for AWWs for Anganwadi Centers are based on the guidelines issued by the Government of India, which are as follows:

"The Anganwadi workers should be a lady (18-44 years) from the local village and acceptable in the local community. Special care should be taken in her selection so that the children of Scheduled Caste and other weaker sections of the society are ensured free access to Anganwadi. It is suggested that the AWW's in the Selected project areas may be selected by a committee consisting of the District Social Welfare Officer, the BDO, the CDPO, the medical officer of the primary health care center, the President of the taluka panchayat/Block advisory committee, the district representative of the State Social welfare Advisory Board and any other non- officials which the State Government may consider appropriate"

The Government of Delhi acknowledges that the recruitment of AWWs are not happening as per stipulated guidelines of the Government of India and is trying to make an effort to ensure that the same happens as per stipulation. This was an observation also noticed during my on-ground field analysis. This deviation affects the effectiveness of the program.

My suggestion to improve the effectiveness of the scheme would be to involve the local community in the selection process which I would term “Social Recruitment” i.e. where the immediate local community to which the Anganwadi would cater, to come together and arrive at a consensus to recruit an AWW based on their perception of capability and likability of an individual to bring synergy in implementation of ICDS

CHAPTER 8: CONCLUSION

After careful analysis of the data, I conclude that Anganwadi centers in Delhi showed some implicit discrimanatory pracatises based on religion which played a role in impeding the access to Anganwadi centers. However, further research is required for concrete results. No discriminatory practises were observed in Wayanad, Kerala. The difference in access in both Delhi and Wayanad is majorly attributed to the obstancles leading from unsatisfactory delivery of services. I hope that the policy recommendations suggested in this paper will help in increasing the access to Anganwadi centers.

Q1. How many member are there in family ?
Q2.how many adult member have an education above class 10 in the house ?
Q3. What is the highest level of education in the house ?
Q4 how many earning member are there in the house ?
Q5.what are their occupation ?(note the responses)
Q6. Which religion are your from?

- Hindu
- Muslim
- Christian
- Jain
- Others

Q7.Which category do you belong to ?
Q8.are there any member in your family from the following categories ?(tick the option , mention how many member from that category)

- 0-3 years
- 3 to 6 years
- 11 to 14 years
- 15 to 19 years
- Pregnant women and lactating mothers

Q9. Are all beneficiarires going to aganwaade?
Yes// no
(other response)

Q10.if no ,why not (if they say,standard of education, is there any other reason
…….(note the response

Q11. If yes ,what all benefits do you avail?

- Complementary nutrition
- Vitamin A supplements
- Iron and Folic Acid Tablets
- Immunization
- Health and check ups

Mention two things you like about this aganwadi ?

Mention two things you don't like about agnavadi

Mention one more recomemendation you would like to see for better functioning of the anganwadi ???
(note the response)
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